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Supreme Court of the United States

OCTOBER TERM, 1956

No. 257

Gordon P. Haynes and Essie M. Haynes, Petitioners,

v.

The United States of America

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR JOSEPH OLIVA AS AMICUS CURIAE

STATEMENT OF JOSEPH OLIVA'S INTEREST AS AMICUS CURIAE

Joseph Oliva, *amicus curiae*, is the petitioner in the case of *Joseph Oliva* v. *Commissioner of Internal Revenue*, now pending in the United States Court of Appeals for the Third Circuit[1] on petition for review of the decision by The Tax Court of the United States in *Joseph Oliva*, 25 T. C. No. 153 (1956).

That litigation involves the taxability of Joseph Oliva on $1,133.10 received by him in 1949 pursuant to a disability benefit plan covering the employees of Esso Standard Oil Company, his employer, and affiliated companies. The outcome of the present case is expected to have a direct bearing on the disposition of such litigation, which

[1] Docket No. 12,038.

has been suspended pending decision here. The instant hearing is likely to provide the last practical opportunity which he will have for presenting his view that disability benefits paid by an employer to his sick and disabled employees, pursuant to a specific arrangement with them established for their protection against the economic risk of accident or ill health, are amounts received "through accident or health insurance" within the meaning of Section 22(b)(5) of the Internal Revenue Code of 1939. This brief is filed, therefore, in support of the petitioners.

SUMMARY OF ARGUMENT

I. There being no contrary indication, Congress presumably intended the term "insurance" to have its normal legal meaning. The legal concept of "insurance" is relatively simple. It consists of nothing more than a contract binding one party to indemnify another in the event of a specified loss. The risk is thus transferred by contract to the "insurer", the party protected is the "insured", and the transaction is "insurance". No particular words or other formalities are required, the matter being entirely one of substance.

II. Disability benefit plans protect employees from loss of earnings by reason of non-service-connected sickness or accident, and materially aid employers in securing and retaining better quality service from employees. Such plans represent one of the considerations of the employment, and the employees' services encompass the *quid pro quo* for the protection and benefits accorded them. Benefits are disbursed on a systematic basis under terms and conditions specifically established in the plan; and accrued rights thereto are non-cancellable.

The risk protected is that of the employee—a risk of loss of earnings through disability. This risk is trans-

ferred to the employer under the plan, and the latter may carry it himself or reinsure it to a varying extent with a commercial insurance carrier by purchase of a group policy specifically geared to the terms of the plan. In the latter case a tentative premium is ordinarily charged and at the end of the term a refund is made of the excess thereof over losses and expenses incurred. Thus only the risk of extraordinary or "non-statistical" incidence of disability, in excess of the premium deposit, is ordinarily transferred to the commercial carrier. The employer therefore functions as an insurer of the employees' risk to a large extent even where commercial coverage is procured, and entirely so where not procured.

At the same time the risk is distributed economically throughout the group of employees as a whole, for the employer assumes the risk of *all* in exchange for services *from them all* as a group. In the aggregate they provide the economic worth which justifies the plan financially, and those who are not disabled contribute services in consideration of the benefits paid those who are.

Since the arrangement is legally binding, it not only is insurance in economic function but also meets the simple requirements of the legal concept of "insurance"—*i.e.*, an undertaking to indemnify in the event of loss.

III. The Court of Appeals misconceived the nature of the plan and benefits paid thereunder. Disability benefits naturally are measured by reference to wages or salary, for their purpose is to replace earnings lost by inability to work. But they are the proceeds of a contract for insurance protection, and thus are not to be confused with mere voluntary wage continuations during sickness. The present benefits were *mandatory*, not "voluntary", and were required by an arrangement having all the essentials of an insurance contract. The court in the present case failed to analyze the legal concept of "insurance", and the facts of the particular arrangement,

sufficiently to determine whether such essentials were present. In its entire opinion it did not cite a single authority or source material in support of its own thinking, nor did it really formulate and apply to the facts involved any concrete meaning of the statutory exemption.

Rather it was preoccupied by formal considerations, and vague notions of statutory construction not specifically related to the issue—particularly the notion of "revenue loss". In the latter connection it clearly has mistaken the judicial function. Congress may or may not be greatly concerned with the potential revenue effect of an exemption, although it seems unlikely here; and in any event, this does not shed any specific light on the meaning of the term "insurance". Congress chose its terminology and this must be followed without regard to general fears of revenue cost, which is solely a legislative concern.

ARGUMENT

I. The Term "insurance" has a well-established meaning, and involves nothing more than a binding obligation of one party to indemnify another in the event of loss.

The Internal Revenue Code of 1939, which governs the present proceeding, provides for the exclusion from gross income of "* * * amounts received, through * * * health insurance * * *, as compensation for sickness." § 22(b)(5). The amount in dispute was clearly received by petitioner, pursuant to the terms and conditions of the disability benefit plan of his employer, Southern Bell Telephone & Telegraph Company, as compensation for sickness (R. 49). The only question, therefore, is whether the amount was received "through * * * health insurance".

The legislative history of Section 22(b)(5), which was first enacted as Section 213(b)(6) of the Revenue Act of

1918, offers no clue that Congress intended to impart a special meaning to the term "health insurance" as used in the statute.[2] Hence it must be presumed to have been used in its normal legal sense. See *Helvering* v. *Le Gierse*, 312 U. S. 531, 540 (1941). In the *Le Gierse* case, this Court had under consideration the meaning of the term "insurance" as used elsewhere in the same revenue act. Pointing out that the committee reports and hearings were "uninformative", the Court proceeded on "the assumption that Congress used the word 'insurance' in its commonly accepted sense."[3]

The "commonly accepted sense" of the term "insurance" is that it consists of an enforceable promise by the insurer to pay a certain sum to the insured upon the happening of a specified contingency, the purpose being to protect against potential loss. Webster defines insurance as "* * * a contract whereby, for a stipulated consideration * * * one party undertakes to indemnify or guarantee another against loss by a certain specified contingency or peril * * *." Webster's New International Dictionary 1289 (2d ed. unabridged, 1947). Health insurance is defined in the same work as "insuring a person against loss due to personal illness resulting in disability." *Ibid.*

Other authorities have defined insurance as a "contract whereby, for a stipulated consideration, one party undertakes to compensate the other for loss on a specified subject by specified perils", Black's Law Dictionary 943 (4th ed. 1951); or as a "contract whereby, for an agreed premium, one party undertakes to compensate the other for loss on a specified subject by specified perils", Bouvier's Law Dictionary 1613 (8th ed. 1914); or as "a contract by which one party for a consideration as-

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[2] See H. R. Rep. No. 767, 65th Cong., 2d Sess. 9-10 (1919). The provision appeared unchanged in subsequent revenue acts and, as Section 22(b)(5), in the Internal Revenue Code of 1939. It was amended in 1942 in respects not relevant here. See Revenue Act of 1942, Secs. 113 and 127(d); Sen. Rep. No. 1631, 77th Cong., 2d Sess. 77, 96 (1943); H. R. Rep. No. 2586, 77th Cong., 2d Sess. 37 (1943).

[3] 312 U. S. at 538-540.

sumes particular risks of the other and promises to pay him or his nominee a certain or ascertainable sum of money on a specified contingency", 44 Corpus Juris Secundum 471 (1945); and the latter source defines health insurance as "an indemnity to persons for expense and loss of time occasioned by disease". *Id.* at 480.

It can be safely concluded that the "authorities are substantially agreed that insurance generally may be defined as an agreement by which one person for a consideration promises to pay money or it equivalent . . . to another on the destruction, death, loss, or injury of someone or something by specified perils", and that as "a general matter, the essential feature of policies of insurance at the present time is substantially that of indemnity to the insured." 29 Am. Jur. 47 (1940).

Thus, in basic legal concept "insurance" involves a relatively simple set of relationships, and should be readily recognized in a given situation. No further element beyond those described above is required, although reference is sometimes made to the pooling of common risks as being characteristic of insurance. See, *e. g., Helvering* v. *LeGierse*, 312 U. S. 531, 539 (1941). However, the latter is merely a frequent business or economic characteristic, rather than a *legal requirement*—as will be appreciated when it is realized that an insurance company creates what is "insurance" in law when it insures a dancer's legs, though the pair involved is unique and none other is insured by such company. The name of Lloyd's of London is virtually synonymous with "insurance", though Lloyd's has long specialized in contracts involving unique situations with little or no opportunity for pooling similar risks.

No particular formal requirements are necessary to insurance. The contract need not be in writing; no particular form of consideration by the insured is required; the insurer's obligation need not be secured by a fund or reserve; and the insurer need not be a commercial in-

surance company. See, *e.g.*, *Commissioner* v. *Treganowan*, 183 F. 2d 288 (2d Cir.), *cert. denied*, 340 U. S. 853 (1950). Conversely, as this Court determined in the *Le Gierse* case, compliance with every possible formality will not make insurance of that which is not. In other words, what constitutes insurance is a matter of substance, and that substance is a contract to indemnify against loss.

II. EMPLOYEE DISABILITY BENEFIT PLANS, SUCH AS THAT INVOLVED HERE, CONTAIN ALL THE ESSENTIALS OF INSURANCE; AND BENEFITS PAID THEREUNDER FALL WITHIN SECTION 22(b)(5) OF THE INTERNAL REVENUE CODE OF 1939.

Admittedly, the record in the present matter does not show, in an evidentiary way, the general nature of employee benefit plans and practices. However, the Court cannot decide the case in a vacuum of information on this subject. Accordingly, one of the principal purposes of this brief is to make sure that the Court has access to fundamental information in the field. An effort is made in the paragraphs which follow, in briefest terms, to put disability benefit protection in its proper context; and in Appendix A hereto there is provided for the Court a short bibliography from which more detailed information is available.

Essential Background Material

Disability benefit protection is distinguished from workmen's compensation protection in that the former compensates for loss of income resulting from non-service-connected disability, whereas the latter compensates for loss of income because of injury or sickness sustained in the course of employment. The principle of workmen's compensation, of course, reaches back into the last century, but it is also true that disability benefit plans of the general nature at issue here and in the *Oliva* case are by no means new.[4] The Telephone Company plan, here involved,

[4] See B. N. Armstrong, *Insuring the Essentials* 370 (1932).

originated in 1913 (R. 49, 56). The Esso Standard Oil Company plan dates back to 1918. Through the years coverage of this type has been extended until more than 39,000,000 workers throughout the United States are presently so protected by formal plans.[5] Moreover, in several states employee disability benefit protection is required by law.[6]

Disability benefit protection may be provided either on a "contributory" basis, *i.e.*, the covered employees make *cash* contributions toward its cost, or on a "non-contributory" basis, in which case they do not make such contributions.[7] Where disability benefit protection is required by law, as in New York, the statute may provide for a modest employee payroll deduction; but even there, a non-contributory plan may be, and frequently is, utilized and accepted as in compliance with the statute.

Despite the fact that disability benefit protection is frequently non-contributory, it would be unduly naive to regard it as something provided "free" to employees by their employers as a voluntary provision springing merely from generosity. The fact is that the cost of disability benefit protection, which runs into many millions, is a significant element of the sum total of economic emoluments exchanged by management with labor for its services.[8] Such protection is highly valued by employers for its beneficial influence on employee morale, efficiency and loyalty to the enterprise—that is, for the quality of the services it engenders. It is prized perhaps even more by employees for its measure of freedom from the fear of economic pressure induced by physical misfortune. Where shops are unionized, disability benefit protection is a

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[5] Health Insurance Council, *The Extent of Voluntary Health Insurance* 25 (1956).

[6] See, *e.g.*, Ch. 600, 1949 Laws of New York.

[7] See Final Report, Subcommittee on Welfare and Pension Funds, Committee on Labor and Public Welfare, S. Rep. No. 1734, 84th Cong., 2d Sess. 14 (1956).

[8] *Id.* at 6-7.

proper subject of collective bargaining;[9] and is considered together with vacation, retirement, medical and other "fringe benefits" in appraising the effective dollar compensation.[10] Invariably, the presence of a disability benefit plan is held out to attract and retain workers, who rely upon it in accepting and continuing employment.[11] It would be fatuous, therefore, to think of disability benefit protection as other than *paid for by the employee's service.*

It would be equally unrealistic to regard disability benefit protection as subject to cancellation or withdrawal at the employer's whim, either as to the employees as a whole or in individual cases. Once a plan is established, there is no turning back the wheel of progress, as a practical matter; and, as will be later demonstrated in this brief,[12] as a matter of legal obligation any benefits accrued—paid for by services—are in any event no longer subject to discontinuance or recall. Many plans in words preserve the employer's right of *prospective* discontinuance of the plan as such, although this may be suspended for a term by union contract; but in the event of discontinuance, it is normally likewise open to the employees to discontinue work, in favor of employment elsewhere on terms and conditions deemed more satisfactory.

Most disability benefit plans have a common structure: All employees are covered automatically[13] after

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[9] U. S. Department of Labor, Bureau of Labor Statistics, *Employee Benefit Plans Under Collective Bargaining*, (Bulletin No. 940) (1948); see also U. S. Department of Labor, Bureau of Labor Statistics, *Digest of One Hundred Selected Health and Insurance Plans Under Collective Bargaining*, (Bulletin No. 1180) (1955); United States Department of Health, Education, and Welfare, U. S. Public Health Service, *Management and Union Health and Medical Programs* (1953).

[10] See A. M. Ross, *Fringe Benefits Today and Tomorrow*, 7 Labor Law Journal 476 (August 1956); *Accident and Sickness Insurance* 10, 12 (McCahan ed. 1954).

[11] See, *e.g.*, *Hearings Before the Committee on Ways and Means on Forty Topics Pertaining to the General Revision of the Internal Revenue Code*, 83d Cong., 1st Sess. 370 (1953).

[12] *Infra*, p. 14 *et seq.*

[13] *Accident and Sickness Insurance* 115, 168 (McCahan ed. 1954).

having been employed a brief waiting period designed to eliminate coverage of floating or temporary personnel.[14] No physical examination is required for admission into the plan, although one is frequently required in connection with original employment. In the event of disability not covered by workmen's compensation, weekly benefits become payable, although only after a waiting period, ordinarily a week,[15] has expired—this to take minor illnesses out of the plan. The latter are variously treated, many employers permitting brief absences for known cause without cessation of pay.

Benefits payable are ordinarily measured by a percentage, sometimes varying with duration of disability, of regular compensation and may be as much as 100% of normal compensation.[16] Benefits are in most cases payable for a stated period of weeks, which may increase with service until, frequently, a full year's protection is available.[17] During the period of benefit payments the employee is subject to medical examination and supervision looking towards assurance of his recovery and return to service as quickly as possible.[18]

There are two basic methods of underwriting disability benefit plans. The persons "insured", *i.e.*, protected against loss of income through physical disability, are the employees. The employer assumes responsibility for this protection, thus transferring the risk to himself. He may then, to a greater or lesser extent, reinsure this risk by procuring an appropriate contract from a commercial insurance company. On the other hand, he may carry the risk entirely himself, in which event he is con-

[14] If the plan is a contributory one, eligibility, rather than coverage, is automatic.

[15] J. V. Strong, *Employee Benefit Plans* 312 (1951).

[16] *Ibid.*

[17] National Industrial Conference Board, Inc., *Studies in Personnel Policy: Health Insurance Plans—Company Non-Contributory Disability Benefit Plans* (1939).

[18] See *Accident and Sickness Insurance* 181 (McCahan ed. 1954).

sidered a "self-insurer". In some states, as in New York, a third method of underwriting is available, *i.e.*, through a state-operated fund which may be termed the "state-insured" plan.

It may surprise the uninformed to discover how little difference there is between the commercially insured and self-insured system.[19] The essential difference is that under the commercially insured plan, the employer ordinarily retransfers a portion—not all—of the risk to the insurance company. This portion, however, is not the usual or ordinary risk, but only the risk of epidemic or other catastrophe—the risk which rarely materializes.[20] This result is achieved through the device of adjustable premiums, or retrospective rating.[21] Under this system, the initial premium for the term is merely a deposit which is subsequently adjusted to cover actual losses and expenses, plus the insurance company's fee for servicing the plan; and the balance of the premium deposit is refunded. Such original deposit is ordinarily calculated to provide more than ample coverage for the anticipated cost, and refunds frequently amount to 30% or more of the deposit. Thus, the risk assumed by the insurance company is not the risk of the ordinary average volume of disability incidence among the group, but only the risk of an extreme degree of disability in the nature of catastrophe.

Employers commonly appreciate this and realize that under the commercially insured plan, as under the self-insured plan, they bear the really significant risk; they and not the insurance company actually pay the disability benefit disbursements; and they do so in the

[19] As stated by one commentator: "Group sickness and non-occupational accident insurance differs from company non-contributory and from joint employer-employee plans largely in that it is handled through an insurance carrier." E. Davis, *Company Sickness Benefit Plans for Wage Earners* 10 (Industrial Relations Section, Princeton University 1936).

[20] National Industrial Conference Board, Inc., *op. cit. supra* note 17.

[21] *Accident and Sickness Insurance* 116, 123, 177 (McCahan ed. 1954).

purchase of better services from their employees. A substantial percentage of disability benefit protection is, therefore, "self-insured".[22] The choice of this method is particularly suitable where the employee group is large, for the distribution of the risk is much wider and the likelihood of "non-statistical" disability incidence is greatly reduced. Moreover, a large group justifies the establishment by the employer of the necessary administrative machinery to operate the plan in much the same way as a commercial insurance company would, and the insurance company is sometimes deemed unable to offer a service that the company cannot provide more cheaply for itself.[23]

If one were to examine the work methods and procedures utilized in the administration of a self-insured plan, it would immediately appear to have the characteristic features of an insurance company operation. The records would be kept, the medical supervision carried on, the cost actuarially calculated, malingering controls exerted, etc., all in accordance with standard insurance company techniques. Indeed, it is not unusual where such a program exists for an insurance company to "insure" the plan but leave its operation to the employer, including the drawing of checks on the insurance company to pay benefits.[24] In such a case, the function of the insurance company is merely to receive the premium deposit, refund the balance at the end of the term, and assume liability for theoretical costs in excess of the premium. It is a matter of business judgment whether the presence of a regular insurance company in such a case is of sufficient advantage to justify the fee charged. Such advantage includes possible greater confidence in the plan on the part of em-

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[22] National Industrial Conference Board, Inc., *op. cit. supra* note 17.

[23] *Hearings Before the Committee on Ways and Means on Forty Topics Pertaining to the General Revision of the Internal Revenue Code, op. cit. supra* note 11, at 367.

[24] See Final Report, Subcommittee on Welfare and Pension Funds, *op. cit. supra* note 7, at 32.

ployees, possible lesser likelihood of abuse on their part, protection of the corporate management from possible criticism in the event of catastrophe losses, etc. On the other hand, the advantages of self-insurance include lower cost, closer employee-employer relationship, and greater appreciation by the employee of the benefits provided.

With this background, the question whether disability benefits, however financed, are received "through accident or health insurance" may be better approached. Several major characteristics of disability benefit protection immediately stand out:

1. In all cases the risk against which a disability benefit system provides protection is the employee's loss of income on account of disability.

2. This risk, and the loss if it materializes, are the employee's risk and loss.

3. The employee pays for his protection against such risk with an economic *quid pro quo* in the form of his services.

4. The risk is transferred to the employer, who may carry it entirely himself as a "self-insurer", or transfer a part of it to a commercial carrier.

5. In the latter event, there ordinarily is transferred in fact only the less significant portion (catastrophe) of the risk.

6. Finally, it is only the presence of the group of employees, within which the risk is distributed, that makes the system economically practicable. That is, the employer assumes the risk of *all* members of the group in exchange for service *from all*. However, only a few in the group will sustain a loss of income from disability and be paid the protective benefits. Accordingly, all members contribute services in order to provide an aggregate of economic worth which will finance the protection of all and the benefit payments to the few who are disabled. Each employee thereby

contributes to the loss of those disabled; and the risk is thus distributed among the group and transferred to the employer who either carries it as a "self-insurer" or retransfers it, to a greater or lesser extent, to a commercial carrier.

All the foregoing is plain, recognizable fact, unassailably true, which would not be seriously disputed by anyone familiar with the field. It should be kept firmly in mind in appraising the legal questions presented by this appeal.

Disability Benefit Protection is "Insurance"

Looking at disability benefit plans generally, and at the Southern Bell plan in particular, one may readily see that such plans fit squarely into the traditional concept of insurance obligations. Physical disability preventing work is a contingency involving potential loss of income. Upon the occurrence of this contingency, a cash benefit, specifically designed to mitigate or eliminate the loss, becomes payable pursuant to the provisions of a carefully worded agreement. The agreement reflects a business arrangement, binding in character and paid for with services, actually set up with the sole purpose of creating the crucial relationship of insured and insurer, within the legal concept of insurance developed above. Nothing is missing, and only one answer is possible.

One must, of course, analyze the arrangement, as is done below, to make sure that it is a contract, that there is binding consideration for it, that the subject is protection against the risk of loss, and that an indemnity is provided therein. But if these are all present, as we submit they are, a finding of "insurance" is inescapable.

Perhaps the most striking aspect of the plan in issue is the careful and lawyer-like fashion in which it is drawn. Obviously it is the product of highly skilled and thoroughly competent legal counsel. And it is equally obvious that it was intended to create enforceable rights

and duties, primarily the payment of specific benefits in the event of disability. The very first sentence of the plan provides that the Company "*undertakes* * * * to provide for the payment of definite amounts to the employees when they are disabled by * * * sickness * * *" (R. 62). This is the language of legal obligations, not of gratuitous benefits. Throughout the plan a careful distinction is made between mandatory and discretionary provisions, as indicated by the use of the words "shall" or "may", or by reference to the "discretion" of Company representatives. It is flatly provided that "the sickness disability benefits * * * *shall* be as follows * * *", and a detailed schedule of benefits is then set forth (R. 72). Again, "Sickness disability benefits *shall* begin on the eighth calendar day of absence on account of disability * * *" (R. 72). (Italics added.)

Finally, section 10 of the plan, entitled "Changes in Plan", provides as follows:

> "The Committee * * * with the consent of the President and subject to the approval of the Board of Directors, may from time to time make changes in the Plan set forth in these Regulations, and the Company may terminate said Plan, *but such changes or termination shall not affect the rights of any employee, without his consent, to any benefit or pension* to which he may have previously become entitled hereunder." (R. 88). (Italics added.)

This provision is sufficient in itself to eradicate any doubt as to whether disabled employees have enforceable rights.

The requirement of consideration is readily met by the services so faithfully rendered by petitioner over a period of more than twenty-five years (R. 49). That it was assumed that the plan constitutes an integral feature of the employment contract and that the employees render their services, in part at least, in reliance on the benefits

of the plan can hardly be questioned in view of the express provision for the distribution of a copy of the plan to each employee upon commencement of his employment with the Company (R. 61). The courts have long recognized that the consideration furnished by the employees in the form of their services is in part given for the so-called fringe benefits, including disability protection, provided by the employer and that the obligation which the employer assumes under a disability benefit plan is one which he cannot escape by asserting that the benefits are gratuitous.

The case of *Cain* v. *Allen Electric & Equipment Co.*, Mich. , 78 N. W. 2d 296 (1956), is squarely in point. There the defendant employer had adopted a "supervisory and office personnel policy" which hardly rose to the dignity of a comprehensive plan, such as the one here involved. The "policy" provided, *inter alia*, for the payment of a specified amount as severance pay, but this provision, like all others, was expressly made subject to change by the employer without any specific reservation of accrued rights. Nevertheless, the court firmly rejected defendant's contention that its declarations of personnel policy were not of a contractual or promissory nature, and instead held that the company was bound by its announced policy. The court stated:

> "We cannot agree that all we have here is a mere gratuity, to be given, or to be withheld, as whim or caprice might move the employer. An offer was made, not merely a hope or intention expressed. The words on their face looked to an agreement, an assent. The co-operation desired was to be mutual. Did the offer consist of a promise? A promise is an expression of intention that the promisor will conduct himself in a specified way or bring about a specified result in the future, communicated in such manner to a promisee that he may justly expect performance and may reasonably rely thereon. (Corbin on Con-

tracts, Section 13). The essence of the announcement was precisely that the company would conduct itself in a certain way with the stated objective of achieving fairness, and we would be reluctant to hold under such circumstances that an employee might not reasonably rely on the expression made and conduct himself accordingly. As for consideration, that element setting apart the enforceable from the unenforceable, we hazard no definition. Suffice in this respect, upon the authority of a multitude of cases, to point out that not only were there rewards to the employee, but, in addition, substantial rewards to the employer, arising, in part, out of the accomplishment of the daily work of the organization in a spirit of co-operation and friendliness. In short, the adoption of the described policies by the company constituted an offer of a contract. This offer, as the trial court correctly held, 'the plaintiff accepted * * * by continuing in its employment beyond the five-year period specified in Exhibit B (the Termination Pay Policy).' The offer having thus been accepted, it was not within defendant's power to withdraw it when called upon to perform. The 'change or amendment' to which the company policy was said, in its preamble, to be subject, could not encompass denial of a contract right gained through acceptance of an offer. To assert otherwise is simply to reassert that there was no contract." 78 N. W. 2d 296, 300-301.

So also in *Chinn* v. *China National Aviation Corporation*, 138 Cal. App. 2d 98, 291 P. 2d 91 (1955), it was held that employee benefit plans of the type with which we are here concerned constitute, technically, offers for unilateral contracts in which the acceptance contemplated is the continued performance of services. In that case the defendant employer adopted regulations providing employee benefits in the nature of severance pay

which amounted to more than $10,000 for an employee in plaintiff's position. Plaintiff, who had previously advised defendant of his intention to terminate his employment forthwith, postponed such action in order to qualify for the newly adopted benefits. The Court sustained his claims, describing the nature of the contract as follows:

> "Of late years the attitude of the courts (as well as of employers in general) is to consider regulations of this type which offer additional advantages to employees as being in effect offers of a unilateral contract which offer is accepted if the employee continues in the employment and not as being mere offers of gifts. They (make) the employees more content and happier in their jobs, cause the employees to forego their rights to seek other employment, assist in avoiding a labor turnover, and are considered of advantage to both the employer and the employees." 138 Cal. App. 2d 98, 99-100, 291 P. 2d 91, 92.

As long ago as the year 1912 it was judicially recognized that fringe benefits tend "to induce employees to remain continuously in the employ of the same master and to render efficient services * * *." *Zwolanek* v. *Baker Manufacturing Co.*, 150 Wis. 517, 521, 137 N. W. 769, 771 (1912).

And similarly in 1922 the Supreme Court of North Carolina stated:

> "It has become a very general policy with large employers of labor to offer a bonus or additional compensation to employees who shall render continuous and efficient service for a specified period of time. This is not a gratuity or gift, but is an offer on the part of the employer, with whom the offer originates in order to procure efficient and faithful service and continuous employment, and when the employee enters upon the service upon that in-

ducement it becomes a supplementary contract of which he cannot be deprived without sufficient cause." *Roberts* v. *Mays Mills*, 184 N. C. 406, 410, 114 S. E. 530, 532 (1922).

This doctrine has also been explicitly applied for income tax purposes, justifying the accrual by an employer of an undistributed, but customary, annual bonus. *Willoughby Camera Stores, Inc.* v. *Commissioner*, 125 F. 2d 607 (2d Cir. 1942).

Indeed, so strong is the doctrine of contract through inducement and reliance in these situations that it has prevailed even though the benefits listed in an "Employee Handbook", which was circulated among the employees, were expressly made subject to discontinuance. *Hercules Powder Co.* v. *Brookfield*, 189 Va. 531, 53 S. E. 2d 804 (1949).[25]

Apparently the Commissioner appreciates the significance of petitioner's contractual right to disability benefits, for he argued below against the existence of any such right, relying on two sections of the plan. These are section 3(3), providing that the committee "shall determine conclusively for all parties all questions arising in the administration of the Plan" (R. 63), and section 8(1) (R. 79), providing, *inter alia*, that no employee has "any right against the Company to any benefit under the Plan other than the amount to which the employee has theretofore become entitled and which the Committee has directed to be paid to that employee under the Plan." Obviously, these provisions relate solely to the administration of the plan and do not empower the committee to dissolve substantial rights of the employees. Section 3(1) clearly so indicates by providing the "Committee shall be charged

[25] Other cases reaching a similar result are Hurd v. Illinois Bell Telephone Co., 30 CCH Lab. Cases ¶ 70,067 (7th Cir. 1956); Psutka v. Michigan Alkali Co., 274 Mich. 318, 264 N. W. 385 (1936); Mabley & Carew Co. v. Borden, 129 Ohio St. 375, 195 N. E. 697 (1935); Kristt v. Haire, 155 N. Y. S. 2d 362 (Sup. Ct. 1956); Hunter v. Sparling, 87 Cal. App. 2d 711, 197 P. 2d 807 (1948).

with the administration of the Plan" (R. 63). Moreover, if this were not so, the entire carefully constructed scheme of benefits, couched in mandatory language, would be wholly meaningless. The second provision relied upon by the Commissioner (Section 8(1)) by its own terms preserves accrued rights (R. 79); and the Company's ability to terminate or change the plan *prospectively* is of no consequence with respect to the status of benefits no longer subject to cancellation. As a matter of fact, a cancellation clause, operating prospectively, is a common provision of commercial health insurance policies.[26]

Moreover, even if the committee had the power to alter the benefits payable, this would, nevertheless, not be inconsistent with the existence of contractual rights. For the committee and the Company are not identical entities, and there is no indication that the committee could or would act in the interest of the Company alone. Rather, in the absence of an express provision to the contrary, it would have to act impartially and fairly, as a quasi-fiduciary, in deciding the questions with which it might be confronted. It is, of course, a well established principle of contract law that a contract may validly delegate to a third party the duty to measure the consideration to be furnished. This rule is succinctly set forth in the Restatement:

> "A bargain in which the only measure of a promisor's duty is whatever valuers or arbitrators shall decide is not illegal unless its terms under the circumstances are unfair." RESTATEMENT, CONTRACTS, Section 551(3) (1932).

All that has been said to the contrary notwithstanding, should the Commissioner nevertheless insist that the plan does grant the committee as agent of the Company the sole power to determine whether any disabled and quali-

[26] R. W. Osler, *Guide to Accident & Sickness Insurance* 55-56, 68-69 (rev. ed. 1955).

fying employee shall receive any benefits at all, the plain answer would be that such a provision would be wholly void. It would give the Company the right to be the judge in its own case, and such provisions have traditionally been held invalid on the ground that they offend public policy. See, *e. g., Wallace* v. *Brotherhood of Locomotive Firemen and Engineers,* 230 Iowa 1127, 300 N. W. 322 (1941).

We have previously mentioned the association of "risk distribution" with insurance, pointing out that it is a common characteristic but by no means a legal necessity. The Commissioner attempted to make something of this below, contending that although the employees shifted the risk of sickness to the Company, the burden of that risk was not borne ratably by all employees, nor ratably by the Company and other employers similarly situated.

It may be noted that the Commissioner concedes tax exemption to amounts received under a commercially insured plan, although we have already pointed out that there is no greater or different transfer or distribution of risk under such a plan, except with respect to the relatively unimportant risk of catastrophe or other extreme non-statistical incidence of disability. (See p. 11, *supra.*) Accordingly, even the Commissioner—if he were right in his contention that there is none in the self-insured plan—would not really require risk distribution. In this connection he would be in good company, for (as also previously pointed out at p. 6, *supra*) commercial insurers generally consider a shift of risk, even if not accompanied by any appreciable risk spreading, as insurance.[27] No one in the insurance world would for a moment doubt that Lloyd's insurance of the dancer's legs was "insurance".

Apart from this, the economics of the plan here involved does present a plain case of risk distribution. As heretofore established, there is a binding contract implicit in this plan and the circumstances surrounding it. The consideration furnished by each employee in-

[27] *Id.* at 110, 133.

the form of continued or more effective service is, both conceptually and realistically, the economic equivalent of a cash premium paid by him. This is his proportionate share of the cost of protection against illness for all employees. The cost of mitigating the danger of potential loss due to illness is thus spread throughout the entire employee group.[28]

Stated differently, each employee's risk that he might suffer loss as a result of disabling illness is pooled with the similar risk of all other employees, and the employer, as insurer, brings together these risks and provides the desired protection in consideration of the services rendered to him by all the employees. By furnishing his part of this consideration each employee contributes economic worth which *in toto* procures the group protection; and he thus contributes to the loss of any disabled person in the group as fully as if he had paid cash of equal worth. The cost per employee of the protection so provided is small because the relatively few cases of protracted illness are balanced by the large number of employees who do not become ill at all or are ill only for very brief periods. In short, the risk of disability due to illness in the present case was shifted from the petitioner (the insured) to the Company (the insurer); and the cost or premium was distributed ratably among all of the Company's employees.

The Court should understand that characterization of disability benefit plans as "health insurance" for purposes of Section 22(b)(5) is by no means a novelty concocted by ingenious counsel for purposes of this litigation. As previously described, plans of this kind date back 40 years or more; and only in relatively recent times has the Commissioner sought to tax the benefits. As late as 1950 the Commissioner publicly expressed the view that a binding obligation to make stipulated payments to an

[28] *Cf. Commissioner* v. *Treganowan*, 183 F. 2d 288, 291 (2d Cir.), *cert denied*, 340 U. S. 853 (1950).

employee in the event of non-service-connected disability constitutes health insurance within the meaning of the statutory exemption. Thus, in ruling upon this issue in connection with a disability benefit plan adopted in accordance with provisions of the California Unemployment Insurance Act the Commissioner said:

> "A voluntary[29] plan which has been approved by the California Employment Stabilization Commission, constitutes a contract of insurance. Such a plan, adopted under the compulsion of State law, is a contract between the employer and his employees which obligates the employer to pay, and entitles the employees to receive, fixed amounts of compensation for personal injuries or sickness for a fixed period. The employees' rights to receive benefit payments under a voluntary plan in consideration of their employment, and the employer's obligation to pay the benefits satisfy the requirements of contract. Furthermore, it seems clear that the contract is one of insurance, as a voluntary plan assures and promises each qualified employee a fixed compensation for a fixed period in the event accident or sickness renders him unable to work. Such assurance is the basic function of an insurance contract. Therefore, such a plan also meets the requirements of Section 22(b)(5) of the Code." I.T. 4015, 1950-1 Cum. Bull. 23, 25.[30]

The only material respect in which the employee disability plan covered by the foregoing ruling differs from the one now before the Court is that the plan was,

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[29] "Voluntary" in the sense that the statutory requirement of disability benefit protection in California is satisfied by an adequate plan voluntarily established by the parties in lieu of statutory benefits. California Unemployment Insurance Act § 450 *et seq.*

[30] I.T. 4015, 1950-1 Cum. Bull. 23, was modified by I.T. 4107, 1952-2 Cum. Bull. 73, but since in the latter ruling it was expressly assumed that the "employer has the sole discretion to determine who shall receive benefits," it can have no bearing upon the present case.

in the words of the Commissioner, "adopted under the compulsion of State law". If, as determined by the Commissioner, a contract supported by proper consideration existed under those circumstances, the present case would, *a fortiori,* involve a contract of insurance for, obviously, it is more difficult to conclude that a transaction constitutes a contract where there is an element of compulsion, than in its absence. Thus, it appears that in the only published ruling in which the Commissioner has really touched upon the essential nature of insurance, he was forced to conclude that disability benefits received pursuant to the provisions of an employer-insured plan are received through health insurance within the meaning of Section 22(b)(5).

The first Court of Appeals to speak on the subject agreed with the Commissioner's reasoning, as announced in the foregoing ruling. *Epmeier* v. *United States,* 199 F. 2d 508 (7th Cir. 1952). In a thoroughly persuasive opinion the court there held on facts closely analogous to those of the present case that payments pursuant to an employee disability benefit plan were "amounts received * * * through * * * health insurance", within the meaning of Section 22(b)(5). The court refused to be led astray by matters of form and, recognizing the basic function and purpose of the plan, unanimously concluded that insurance was involved.[31]

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[31] Other cases dealing with the issue here involved and reaching a result favorable to the taxpayer are *Adams* v. *Pitts,* 140 F. Supp. 618 (E. D. S. C. 1956); *Tinsley* v. *United States,* 56-2 USTC ¶ 9604 (W. D. Okla. 1956); *Priebe* v. *United States,* 56-1 USTC ¶ 9478 (D. Ariz. 1956), and *Herbkersman* v. *United States,* 133 F. Supp. 495 (S. D. Ohio 1955).

The only other opinion of a Court of Appeals dealing with the present issue is that of the Ninth Circuit in *Moholy* v. *United States,* 56-2 USTC ¶ 9745 (9th Cir. 1956). While the case is clearly distinguishable in that there the disability benefits were received by a city employee pursuant to the provisions of a city and county charter and local ordinances and regulations, not under a contract freely entered into by employee and employer, the court ignored this distinction. In holding that the disability payments were not exempt from tax under §22(b)(5), the court gave a great variety of rea-

In the absence of illuminating legislative history, it seems highly probable to us that the court in the *Epmeier* case put its finger on the Congressional purpose when it said that the statute was "undoubtedly * * * intended to relieve a taxpayer who has the misfortune to become ill or injured, of the necessity of paying income tax upon insurance benefits received to combat the ravages of disease or accident." (199 F. 2d 508, 511.) It is in no way apparent how this purpose would be served by drawing an artificial line between commercially-insured and privately-insured arrangements, and it seems inconceivable that Congress should have intended either (*a*) to impose a discriminatory tax upon disabled taxpayers, such as petitioner here, whose employer in the exercise of sound business judgment has chosen to administer an employee health insurance program himself, rather than delegate its administration to a commercial insurance company; or (*b*) to channel all such plans into the hands of commercial insurance companies by turning the weapon of severe tax penalties against privately-administered plans. Moreover, the whole tenor of Section 22(b)(5) rejects any such narrow distinction, for it is clearly comprehensive in scope, exempting not only amounts received through health insurance as compensation for personal injury or sickness, but also workmen's compensation payments and damages received on account of personal injuries. Congress quite plainly sought to soften the unexpected blow of disabling injury or disease, and in this spirit could not have intended to deprive privately-insured plans of such treatment.

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sons, but not once in its opinion did it address itself to the fundamental question of what constitutes insurance.

Other cases sustaining the Commissioner with respect to the taxability of employee disability benefits are *Cary* v. *United States*, 141 F. Supp. 750 (D. Neb. 1956); *Hanna* v. *United States*, 56-2 USTC ¶ 9736 (N. D. Tex. 1956); *Gamble* v. *United States*, 56-2 USTC ¶ 9666 (S. D. Tex. 1956); *Townsend* v. *United States*, 56-2 USTC ¶ 9813 (S. D. Ill. 1956); *Branham* v. *United States*, 136 F. Supp. 342 (W. D. Ky. 1955); *Joseph Oliva*, 25 T.C. No. 153 (1956); *Milton W. McQueen*, 15 CCH Tax Ct. Mem. Dec. 21,797(M) (1956).

In other areas of the Internal Revenue Code the courts, as well as the Commissioner, have looked to the nature of insurance, not to its commercial or formal characteristics, in order to determine whether a particular arrangement constitutes insurance within the meaning of a particular statutory provision. That this Court, in determining what constitutes "insurance", has not been impressed with the formal attributes of a purported policy of insurance is forcefully demonstrated by its unanimous opinion in *Helvering* v. *Le Gierse*, 312 U. S. 531 (1941). The Court there had no difficulty in holding that the "mere presence of the customary provisions" of an insurance policy cannot provide the answer to the question whether or not insurance is involved. Nevertheless, the Commissioner here urges little more than that the mere absence of the "customary provisions" of a commercial insurance policy is decisive of the present controversy.

Though the Commissioner apparently has chosen to ignore the teaching of the *Le Gierse* case, the lower courts have repeatedly relied upon it in adopting a realistic approach to the problem of defining insurance. Thus, in *Commissioner* v. *Treganowan*, 183 F. 2d 288 (2d Cir.) *cert. denied*, 312 U. S. 853 (1950), the court held that a plan under which each member of a group was entitled to a death benefit of $20,000 and was obligated to contribute $15 to a like benefit upon the death of any other member constituted insurance. It analyzed the concept in terms of its essential elements of risk or fortuity, rather than by reference to formalistic folderol.[32] That the fortuity there was death, whereas here it is sickness, cannot affect the result. Nor could the meaning of insurance be affected by the fact that there it was the Commissioner who urged a recognition of the substance of the transaction, while here it is the taxpayer. And, incidentally, in view of the Commissioner's present insistence upon the existence of a separate fund as a vital

[32] *Cf. Knight* v. *Finnegan*, 74 F. Supp. 900 (E.D. Mo. 1947).

ear-mark of insurance, it is interesting to note the court's recognition in the *Treganowan* case that, historically, insurance was not funded and that non-funded plans of risk shifting and distribution "have always been understood to be insurance * * *."[33] Indeed, Judge L. Hand suggested in a separate opinion dissenting on another aspect of the case that the presence of a separate fund reduced the similarity to insurance.[34]

The Tax Court has also followed the *Treganowan* approach to the matter. See *William E. Edmonds*, 16 T. C. 110 (1951). In holding the death benefit plan there involved to be life insurance the Tax Court made it plain that deviation from the universal customs of commercial life insurance could not affect the result, for it specifically found that there was "no plan of [commercial] life insurance in existence" which contained identical provisions.[35] Similarly, the Commissioner conceded that a municipally financed employee death benefit was insurance for purposes of the estate tax in the case of *Kernochan* v. *United States*, 29 F. Supp. 860 (Ct. Cl. 1939), *cert. denied*, 309 U. S. 675 (1940).

III. THE COURT BELOW MISCONCEIVED THE NATURE OF THE PLAN AND OF THE CONGRESSIONAL PURPOSE IN ENACTING THE STATUTE, AND TOTALLY IGNORED BOTH THE ECONOMIC AND LEGAL MEANING OF THE TERM "INSURANCE."

The opinion of Circuit Judge Brown, dissenting below, inspires immediate confidence because it displays some practical knowledge of the subject matter. The majority opinion, in contrast, is immediately suspect because it discloses several rudimentary misconceptions as to

[33] 183 F. 2d 288, 291.

[34] 183 F. 2d 288, 293.

[35] 16 T.C. 110, 115. *Cf. William J. O'Shea*, 47 B.T.A. 646 (1942), in which the Board, in holding an annuity not to be insurance, stated: "Nor is the fact important that the obligor on the contract was the [Teachers' Retirement] System and not an insurance company." 47 B.T.A. 646, 652.

what disability benefits are and how they are provided. Even more distressing, these very misconceptions seem greatly to influence the conclusions reached. The majority opinion (R. 103 *et seq.*) is relatively brief, and we believe it will be most enlightening to examine it paragraph by paragraph.

The issue is stated in the first paragraph. The second is confined to several generalities about statutory construction in the tax field, the substance of which is that the boundaries of tax inclusion and exclusion are fixed by Congress, not the courts, and must be so applied. This rule is doubtless acceptable to both parties here.[36]

In the third paragraph of its opinion the court quotes the statute, and then reveals its first thought on the issue, saying that the taxpayer seeks exemption of an amount "which in fact comes to him as a continuation of his regular salary during sick leave". The court thus freely equated the benefits paid with salary which an employer might voluntarily continue to pay an employee who is unable to come to work because of illness. In so doing the court disclosed its failure to grasp the real nature of a disability benefit plan.

Disability benefit insurance is *income* protection. Its very purpose is *to replace salary payments* which are lost. There should be no surprise, therefore, that the benefit payments bear some resemblance to the beneficiary's "regular salary"; or that their receipt is ultimately traceable to his having rendered services. However, the thing which is earned by the employee's services is the protection afforded by the plan itself, which gives

[36] The notion of "revenue loss" is first introduced in this paragraph, but nothing specifically is made of it *vis-a-vis* the issue at hand; and in the sixth paragraph of the opinion there is a vigorous denial that any "such loss has any part in enabling the Court to construe a statute." One must be careful when thinking in terms of "lost revenue." Probably the most serviceable concept of a "revenue loss" is the sacrifice of a measure of revenue which the fisc *has previously been enjoying*. It has been only in recent years that the Treasury has attempted to tax benefits of the kind here involved—so that it more properly should be regarded as seeking *revenue expansion*, rather than preventing revenue loss.

the employee vested rights to payments in the event of personal misfortune. These rights are what he earns, and which constitute a "fringe benefit" in addition to his salary, just as the employer's payment of a premium to an insurance company for similar rights would be. The payments received by the employee under the plan are simply a realization upon such rights or, in other words, the collection of insurance, just as would be his collection of the same sums from an insurance company. It is a mistake, therefore, to confuse the benefit payments with his "regular salary".

The difference which the court overlooks, of course, is that wages are paid for the performance of services, and disability benefits are paid because the disabled employee has a right to them under a contract of insurance and such right accrues because of *inability* to render services. No employee will ever receive such payments while he is performing services for the Company, no matter how many years he has rendered services and no matter how diligently and faithfully he has done so. Only if he does *not* render any services, due to disability, will he become entitled to the benefits; and as soon as the disability terminates the payments will terminate as well.[37]

Beyond the foregoing, no distinction between wages and sickness benefits is necessary or, indeed, appropriate, for the very purpose and function of health insurance, as pointed out above, is to provide benefits which will resemble as closely as practicable the income which has been lost as a result of the disability. As stated by the president of a large insurance company:

> "The prime purpose of disability insurance is to replace income lost to the worker who has been incapacitated through accident or sickness. The need of some social device for the continuance of income

[37] The plan specifically provides that "Employees shall not be entitled to receive sickness disability benefits for time for which any wages are paid them by the Company" (R. 73).

during disability has long been recognized and stems directly from the very wide dependence on earned income by the individual and his family. The importance of current earning ability of the breadwinner to the average family cannot be over-emphasized."[38]

and again:

"Disability insurance finds its useful function in continuing the income for the insured during the time when, by reason of illness or injury he is unable to earn."[39]

In the fourth paragraph of its opinion the court speaks of the plan as "voluntary"—a clearly erroneous characterization unless intended to mean nothing more than that the establishment of the plan was not required by statute. Contracts (insurance or otherwise) are normally voluntarily made, but this does not detract from their enforceability; and it is clear that the benefit payment at issue was a legal obligation of the Company.

In the same paragraph the court states that "it cannot be disputed that there is no separate contract or agreement of insurance". This is a concession to which the court is plainly not entitled. As we have developed at some length already, the whole disability benefit plan was exactly that—a contract or agreement of insurance—and this fact cannot be hidden by gratuitously asserting that "it cannot be disputed" that there was no such contract or agreement. If the stress was intended to be on the word "separate", we ask "separate" from what? The plan itself is the insurance contract, and it certainly seems "separate" enough. Further, why and whence this need for "separateness"?

The final sentence in the paragraph asserts that Congress had in mind payments "definitely and with binding

[38] Accident and Sickness Insurance 16 (McCahan ed. 1954).
[39] *Id.* at 18.

force fixed by an insurance contract between the employe and an insurer. * * *" No specific evidence is offered that this was in fact the "concept" of Congress, but in any event all elements of it are present here. The plan represented an insurance contract which with binding force fixed specific amounts to be paid ($2,100) to petitioner, and under which the Company was the insurer and the petitioner the insured.

In the next (fifth) paragraph of its opinion, the court attributes to the Congressional mind—again without specific evidence—a "clearly defined class" which is "readily identified" by having "attributes or characteristics associated with the term 'insurance' ". This class, the court continues, consists of those "who, for a definite consideration, having an actuarial relation to the benefits provided, paid by them or on their behalf, obtained insurance coverage under ordinary insurance standards". This test seems to come perilously close to insisting that the parties deal with a commercial insurance company[40]—and it is quite a bit to distill out of a single word ("insurance") without pointing to a shred of statutory language, legislative history, or judicial precedent in support of such meaning. This from a court which has opened its opinion with a strong condemnation of "judicial legislation" and "judicial fiat"!

The court thus announces a test of its own making, but totally fails to see that the present situation passes it with flying colors. The court did point out the respects in which it apparently thought the plan did not measure up to its test. It spoke of the payments as "payments of salary or wages by the voluntary action of his employer during sick leave"—although the payments were no more "voluntary" than in the case of any other insurance; and were not salary or wages, but benefit payments designed

[40] Congress could never have intended any such thing, for it would have penalized privately-insured plans and subsidized commercial insurance companies in a most outrageous manner. See page 25, *supra*.

to compensate for loss of income when salary or wages could not be earned.

There was mention also of some evidence (dubious) in the trial court that commercial carriers do not ordinarily insure 100% of income. This, of course, is a matter of premium cost; and there are few situations in the insurance field where full coverage is not available if one is a good moral risk and is willing to pay the necessary premium. Even the plan in question provided a benefit equal to full pay for a year only if the employee had 25 years' service with the Company (R. 72)—ample consideration, and excellent evidence of a sound moral risk.

The court also pointed out that the payments were not made "on an actuarial basis in relation to the amount of risk or to any other factor of age, state of health, or anything else". This is, indeed, an amazing comment! Obviously, the payments were made in exactly the same circumstances, for exactly the same reasons, and in exactly the same amount as would have been the case if a commercial insurance carrier had issued a policy to the Company and made the payments to the petitioner, using the Company's premium deposit for the necessary funds. The cost was as fully subject to actuarial computation as if a commercial insurance carrier were involved; and the Company doubtless knew better than an insurance company the cost of this *quid pro quo* which it was willing to give for services rendered.

In group insurance, as most everyone knows, the health of particular members of the group is normally disregarded, freedom from "insurability" being a principal advantage of such insurance.[41] The ages and sex

[41] As stated in Accident and Sickness Insurance at 115 (McCahan ed. 1956) ". . . group insurance is usually issued without any requirement of evidence of insurability from the individuals to be insured. Evidence of insurability can be waived because the individuals who are eligible for the insurance are bound together as a group by some strong interest other than that of obtaining insurance. As one would expect from general considerations, experience has shown that the natural interest of the employer in selecting efficient employees acts as a method of selection of lives so that the insured group will usually have normal and predictable morbidity."

of the employees were, of course, known to the Company; and statistical data on disability incidence are freely available to anyone interested. Add to this the Company's own experience with this group and plan for more than 35 years, and one inescapably wonders how a realistic court could assume that the probable cost was unknown to the Company or that it was not determined in the same way (in fact, the only possible way) as would have been done by a commercial insurance carrier.[42]

Further, it is stated that "no reserves were set up as is ordinarily done in the case of insurance"—but the solvency of the Telephone Company (the *raison d'être* for legally required insurance reserves) is not questioned, and may be safely assumed. Finally, it is stated that the "benefits were voluntarily fixed by a management committee"—a plain misconception of fact, as the benefits were specifically and expressly scheduled in the plan and were mandatory in character (R. 72).

To cap all this, the court itself observes in this same fifth paragraph that these indicia are cited "not to prove that the Company's plan here was unlike insurance"—as, indeed, they surely do not prove. What, then, makes the court feel that its own test of "insurance" is not satisfied? It offers nothing further, and it is more than clear that petitioner paid a "definite consideration"—services rendered for more than 25 years; that he obtained "insurance coverage"—contractual indemnity against loss; and that all this met "ordinary insurance standards"—indeed, could all have been readily reinsured with a commercial carrier, if the Company had so desired, without change of substance.

In this fifth paragraph and in the sixth the court speaks again of "loss of revenue", seemingly reasoning that Congress would not grant an exemption without

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[42] Moreover, actuarial computation of cost is not an indispensable element of insurance. See, *e.g.*, *General Life Insurance Co.* v. *Commissioner*, 137 F. 2d 185 (5th Cir. 1943); *cf.* G.C.M. 5921, VIII-1 Cum. Bull. 179.

knowing specifically what it would mean in terms of revenue sacrifice; and that it, therefore, must have had a concept of the exemption in mind so definite as to make measurement of the "lost" revenue possible. Even if a valid hypothesis—which is extremely doubtful—this in itself does not assist in identifying the particular supposed Congressional concept; nor is it even evidence that a court-invented narrow concept is more likely to be correct than a taxpayer-invented broader concept, the revenue implications of both being equally capable of estimation. Other evidence would be needed to ascertain whether Congress intended the broad or the narrow.

We cannot escape the belief that Judge Tuttle, by reason of experience with revenue legislation formulated in times of budgetary stress, has instinctively sought to reduce the scope of the exemption to commercial carrier transactions—something which Congress never wrote into the statute; which would be most difficult to justify, for reasons already developed, as a matter of legislative policy; and which he cannot add to the Code as a judge, however sure he may be that he would have done so had he drafted this tax legislation.

Indeed, the sensitiveness to revenue needs instilled in this judge by his experience with revenue legislation in recent times misleads him as to the Congressional viewpoint on Section 22(b)(5). Congress made it plain that it was not in a penurious mood in 1919 when it first enacted the provision which later became Section 22(b)(5).[43] On the contrary, prompted by the sudden end of World War I, Congress was actually trying to effect a *substantial reduction* of revenues. As stated by the Senate Finance Committee:

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[43] Section 22(b)(5) of the Internal Revenue Code of 1939 is traceable to Section 213(b)(6) of the Revenue Act of 1918. The pertinent language remained unchanged during the period from the date of its initial enactment to the taxable year here involved.

"The task of financing the operations of a great war gave way to the task of financing the Government through a period of reconstruction and demobilization * * *. The cessation of the war, therefore, brought with it not only the opportunity but the necessity of *reducing the large tax budget* which the House had voted." S. R. 617, 65th Cong., 3d Sess. 1-2 (1919). (Italics added.)

Moreover, the possibility, remote as it may be, that Congress had in contemplation an ascertained amount of exempt income when enacting the statute could hardly affect the scope of the exemption granted. It would be an odd principle of construction which would narrow the scope of "insurance" progressively as the total of insurance proceeds annually received by the taxpaying public increases. Indeed, it is far more likely that Congress, recognizing the social desirability of accident and health insurance, including the establishment of plans of the type at issue here, hoped for the very expansion of such insurance which has in fact occurred, regardless of any revenue loss involved. Moreover, it was always open to Congress to call a halt when it felt the exemption had outgrown the revenue structure and needs; and this was done in 1954 when the exemption was limited to a stated weekly sum —without, however, discriminating between commercially insured and privately insured plans (I. R. C. 1954, Section 105).

In the seventh paragraph of its opinion the court, having offered nothing beyond its own statements to justify its interpretation of the statute, resorted to what the term "insurance" would mean to the "average person". Is it to be assumed that Congress had in mind the "average person" *familiar with insurance*, or the "average person" *not* familiar with it? Surely the former, if any. We submit that one need know very little of

the subject to realize that a formal disability benefit plan, such as is here involved, is an insurance arrangement.

Finally, the court in evident desperation urges that the term "through insurance" in the statute must be given *some* meaning, which would not be the case if *all* compensation for sickness were exempt. With this we agree, but we do not urge that *all* compensation for sickness is exempt. We urge only that where all the fundamentals of insurance in the legal sense are present, the exemption should not be arbitrarily granted in one case and taken away in another merely to narrow—by "judicial fiat"—the scope of the exemption.

Doubtless the line at which wage continuations will be taxed under the statute must ultimately be drawn, but not necessarily in this case where the insurance elements are so clear. Mere voluntary wage continuations, determined at the moment, clearly would not qualify for the "insurance" exemption. Those employment arrangements which simply contemplate in advance that an employee will not be "docked" for absence due to illness up to a specified number of days are more difficult. Such arrangements may be little different from other paid "annual leave"—whether for military encampment, for vacation, or as "sick" leave. When the parties deal in terms of an arbitrary allowance of "leave" that will be available for various purposes without loss of pay, perhaps they do not deal in terms of a risk of loss and indemnification therefor; and may not create an insurance relationship. But this possibility presents no problem here, where the whole purpose and function of the arrangement are born of a desire that the employer assume, on specific terms, what the parties conceived of as a risk of loss capable of protection by the device of insurance.

There is nothing further in the opinion except its disagreement with the *Epmeier* case. We believe that we

have treated every point upon which the court relied.[44] When added together, they sum up to very little. The logic is obscure, and in part based on serious misconception of fact. "Boot-strapping" is visible. The total absence of the *most pertinent inquiry of all*—the meaning of the term "insurance" as developed in the law—is painfully obvious. Heavy reliance on considerations of revenue loss as an ill-defined interpretative aid, as well as on such a feeble crutch as the grasp of language by the hypothetical "average person", is a warning signal that here is a court having trouble justifying a preconceived result. This is the surest sign that the result, itself, is wrong, for if it cannot be better justified, it should not prevail.

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[44] The court apparently intended its final comment to the effect that the insurance must be "bought and paid for by the payment of premiums consciously and knowingly made for 'health insurance'" as a repetition, not a further argument. In any event it was the express policy of the Company to acquaint new employees promptly with the terms of the plan (R. 61), and the employees surely consciously and knowingly rendered their services in reliance upon the promises contained in the plan. (That premiums for insurance may consist of a form of consideration other than cash is well established. See, *e.g.*, *Ollendorf Watch Co. Inc.* v. *Pink*, 279 N. Y. 32, 17 N. E. 2d 676 (1938).) It is common knowledge that fringe benefits of the type provided by the plan are an extremely important factor in attracting and retaining personnel. Indeed, employees are sufficiently conscious of the value of such benefits to make them frequently a principal subject of employee-employer bargaining (see Accident and Sickness Insurance 10, 12 (McCahan ed. 1954)) and, surely, it cannot be necessary that in order to qualify as health insurance the mental image evoked by reference to sickness disability protection must appear in the employee's mind as the precise and technical term "health insurance."

CONCLUSION

On the basis of the foregoing, it is urged that the decision of the Court of Appeals be reversed.

Respectfully submitted,

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APPENDIX A.

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